U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 01 December 2004

CASE NO.: 2004-BLA-25

In the Matter of

RAYMOND FLEMING,
Claimant

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard Stayton, Esq.,
For the Claimant

Karen Barefield, Esq.,
For the Director

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on June 2, 1994, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his claim for benefits on June 2, 1994. (Director's Exhibit ("DX") 1). The claim was denied by the Department of Labor because the evidence failed to establish the elements of entitlement that Mr. Fleming had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. (DX 13). On November 11, 1994, the claimant requested a hearing before an administrative law judge. Mr. Fleming's claim has an extensive, ten-year long, procedural history consisting of repeated hearings, continuances and remands to the District Director. Mr. Fleming filed a second application for benefits on July 23, 2002. As of July 23, 2002, no administrative law judge had issued a decision on the June 2, 1994 claim. On November 3, 2003, the case was again referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on November 24, 2003. On March 4, 2004, I issued an Order holding that the July 23, 2002 claim is merged with the June 2, 1994 claim. The effective date of filing for this claim is June 2, 1994.

On May 20, 2004, I held a hearing in Charleston, West Virginia, at which the claimant and Director, Office of Workman Compensation Programs were represented by counsel.[1] The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-7 and Director's exhibits ("DX") 1-122 were admitted into the record.

Claimant submitted the following evidence after the hearing:

i. Rereading of 12/12/96 X-ray by Dr. T. Miller;
ii. Rereading of 12/12/96 X-ray by Dr. K. Pathak;
iii. Rereading of 4/9/99 X-ray by Dr. K. Pathak;
iv. Qualifications of Dr. T. Miller;
v. Qualifications of Dr. K. Pathak;
vi. Rereading of 7/8/94 X-ray by Dr. A. Ahmed;
vii. Rereading of 7/8/94 X-ray by Dr. K. Pathak;
viii. Rereading of 10/17/02 X-ray by Dr. T. Miller;
ix. Rereading of 10/17/02 X-ray by Dr. E. Cappiello;
x. Rereading of 10/17/02 X-ray by Dr. A. Ahmed;
xi. Rereading of 10/17/02 X-ray by Dr. K. Pathak;
xii. Rereading of 10/17/02 X-ray by Dr. E. Aycoth;
xiii. Qualifications of Dr. E. Aycoth;
xiv. Rereading of 7/8/94 X-ray by Dr. B. Brandon;
xv. Rereading of 4/9/99 X-ray by Dr. B. Brandon; and
xvi. Qualifications of Dr. B. Brandon.

These exhibits are hereby admitted into the record and marked as Claimant's Exhibits (CX) 8 through 23, respectively.

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

Closing arguments were submitted by Claimant's counsel and the Associate Regional Solicitor post-hearing.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 24 years. (DX 2, 3, 4).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on June 2, 1994. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[2]

On April 26, 2004, the undersigned issued an Order Dismissing Island Creek Coal Company as the responsible operator and named the Director, Office of Workers' Compensation Programs as the respondent to Mr. Fleming's claim.[3] Thus, any liability for an award would fall upon the Black Lung Disability Trust Fund.

[2] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator, or if the responsible operator is unknown or is unable to pay benefits, with the Black Lung Disability Trust Fund. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

[3] On March 4, 2004, the Undersigned issued an Order to Show Cause responding to Employer's Notice of Contested Responsible Operator Issue. The Order required the Director to show cause why the responsible operator should not be dismissed. No response was received to the Show Cause Order. Thereafter, on April 26, 2004, the Undersigned issued an Order Dismissing Island Creek Coal Company.

D. Dependents[4]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife Mary Rose Cline. (DX 96).

E. Personal and Employment History

The claimant was born on October 22, 1930. (DX 1). He married Mary Rose Cline on September 5, 1997. (DX 96). The Claimant's last position in the coal mines was that of an electrician. (DX 77). Claimant testified that his job required him to lift 50 to 75 pounds. He stated that his job was strenuous "at times." His position required him to work both underground and at the tipple of the mine. (DX 77). Mr. Fleming completed ninth grade. (DX 77).

II. Medical Evidence

A. Chest X-rays[5]

There were 54 readings of five X-rays, taken on July 8, 1994, December 12, 1996, April 9, 1999, October 17, 2002 and November 27, 2002.[6] Thirty-two are positive, by eight physicians, Drs. Ahmed, Alexander, Aycoth, Brandon, Cappiello, Miller, Pathak and Ranavaya, all of whom are either B-readers, Board-certified in radiology, or both.[7] Twenty-one are negative, by ten physicians, Drs. Cole, Gaziano, Harron, Hayes, Navani, Ranavaya, Scatarige, Scott, Wheeler and Zaldivar, all of whom are either B-readers, Board-certified in radiology, or both. Dr. Gaziano provided a quality-only reading of the October 17, 2002 X-ray. A summary of the Chest X-ray evidence is hereby attached as Appendix A.

B. Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

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[4] See 20 C.F.R. §§ 725.204-725.211.

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[6] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[7] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Physician Date Exh.#	Age Height	FEV₁	MVV	FVC	Trac- ings	Compre- hension Coopera- tion	Qualify * Conform **	Dr.'s Impression
Dr. Zaldivar 11/27/2002 DX 103	72 69'	1.72		2.54	Yes		No Yes	Poor effort invalidated all the tests.
Dr. Zaldivar 11/27/2002 DX 103 Post-Bron	72 69'	1.43		2.49	Yes		No Yes	Poor effort invalidated all the tests.
Dr. Walker 4/9/1999 DX 52	68 68.5'	2.35	89	3.04	Yes	Good Good	No Yes	
Dr. Ranavaya 1/31/1997 DX 34	66 70'	2.57	97.6	3.39	Yes	Good Good	No Yes	
Dr. Ranavaya 12/12/1996 DX 32[8]	66 70'	.87		1.01	Yes	Fair/Poor Fair/Poor	Yes Yes	Mr. Fleming made 3 attempts and complained of S.O.B., dizziness and he declined from further attempts. Spirometry is inconclusive due to submaximal effort.
Dr. Ranavaya 7/8/1994 DX 8	63 69'	2.67	35.8	3.45	Yes	Good Good	No Yes	
Dr. Ranavaya 7/8/1994 DX 8 Post-Bron	63 69'	2.56	54.5	3.18	Yes	Good Good	No Yes	

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

[8] Dr. Gaziano is a B-reader and Board-certified in internal medicine and chest disease. Dr. Gaziano reviewed the December 12, 1996 pulmonary function study and concluded that the vents are not acceptable do to very poor effort. (DX 33).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 69.2 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.82 for a male 71 years of age.[9] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.35 or an MVV equal to or less than 73; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	**Age**	**FEV_1**	**FVC**	**MVV**
69	71	1.82	2.35	73
68.5	68	1.81	2.33	72
70	66	1.96	2.52	79
69	63	1.95	2.49	78

C. Arterial Blood Gas Studies[10]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

[9] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 69.2" here, his average reported height.

[10] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…

(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
11/27/2002 DX 103	Dr. Zaldivar	41	63	No	
10/17/2002 DX 97	Dr. Ranavaya	37	60	Yes	The exercise arterial blood gas study was not done due to resting arterial blood gas study meeting US federal criteria for total disability contained in 20 CFR 718. Mr. Fleming declined from undergoing exercise arterial blood gas study.
4/9/1999 DX 54	Dr. Walker	36.0	61	Yes	Exercise not performed due to painful knees.
12/12/1996 DX 36[11]	Dr. Ranavaya	37.3	60.4	Yes	Exercise study not done due to resting arterial blood gas met the federal criteria contained in 20 CFR 718.
11/8/1995 DX 30	Dr. Goo V.A. Medical Center	33	58	Yes	
7/8/1994 DX 9	Dr. Ranavaya	37.8	69.2	No	

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Zaldivar is a B-reader and is Board-certified in pulmonary diseases, internal medicine, sleep disorder and critical care medicine. His examination report, based upon his examination of the claimant, on November 27, 2002, notes thirty-four years of coal mine employment. Dr. Zaldivar noted that Claimant never smoked. In addition to examining Claimant, Dr. Zaldivar reviewed the Claimant's medical records. (DX 103). Dr. Zaldivar described the

[11] Dr. Gaziano is a B-reader and Board-certified in internal medicine and chest disease. Dr. Gaziano reviewed the December 12, 1996 arterial blood gas study and concluded that the test is technically acceptable. (DX 33).

claimant's symptoms as shortness of breath for 15 years, occasional wheezing, and occasional cough. He also noted that Claimant sleeps on three pillows because of shortness of breath for 19 years. Claimant has never smoked. (DX 103).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Zaldivar concluded there is "no evidence in this case to justify a diagnosis of coal workers' pneumoconiosis nor any dust disease of the lungs." (DX 103).

Dr. Zaldivar stated that there is no evidence of any pulmonary impairment. He opined that Claimant's complaints of shortness of breath are not the result of any pulmonary condition. Dr. Zaldivar explained that the shortness of breath could be the result of general deconditioning or the effect of advanced age. He concluded that Mr. Fleming is fully capable of performing his usual coal mining work. Dr. Zaldivar stated "from the pulmonary standpoint, Mr. Fleming is fully capable of performing arduous manual labor if so were required." (DX 103). Dr. Zaldivar noted that a finding of coal workers' pneumoconiosis would not change his opinion regarding pulmonary capacity.

Dr. Zaldivar opined that the breathing test he performed was worthless, due to poor effort. Claimant chose not to redo the test, stating that it was the best he could do. No exercise tests were performed due to Claimant's orthopedic problems. (DX 103).

Dr. Zaldivar noted that claimant's complaint of difficulty with wheezing related to chemicals raises the possibility that Claimant may have asthma. Dr. Zaldivar noted, however, that none of the medical records show any treatment for asthma. (DX 103).

Dr. Ranavaya, a B-reader, submitted an examination report, based upon his examination of the Claimant, on July 8, 1994. Dr. Ranavaya noted 35 years of coal mine employment and that Claimant never smoked. He listed Claimant's medical history as including pneumonia and high blood pressure. Dr. Ranavaya described Claimant's current symptoms as sputum, dyspnea, cough, orthopnea and paroxysmal nocturnal dyspnea. He stated that Claimant also complains that "he becomes short of breath walking about one city block on level ground, climbing about 1 flight of stairs or walking up a gentle incline for about 200 feet." Dr. Ranavaya noted that on auscultation there was minimally prolonged expiratory phase with scattered few expiratory wheeze. (DX 8).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Ranavaya diagnosed hypertension based upon Claimant's history. Dr. Ranavaya did not note any degree of impairment. (DX 8).

Dr. Ranavaya submitted an examination report, based upon his second examination of the Claimant, on December 12, 1996. Dr. Ranavaya noted 25 years of coal mine employment and that the Claimant never smoked. Dr. Ranavaya noted that Claimant has the following medical history: pneumonia, attacks of wheezing, heart disease/exertional angina, diabetes mellitus, and high blood pressure. Dr. Ranavaya listed Claimant's symptoms as sputum, wheezing, dyspnea, cough, chest pain, orthopnea, and paroxysmal nocturnal dyspnea. Dr. Ranavaya also noted "Mr. Fleming states that he becomes short of breath when walking about 400 feet on level ground, climbing 7 steps upstairs, [and] he states that he cannot walk any inclines." (DX 35).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed pneumoconiosis. He also diagnosed exertional angina and hypertension. Dr. Ranavaya opined that Claimant's pneumoconiosis is caused by occupational exposure to coal dust. (DX 35).

Dr. Ranavaya concluded that Claimant has a severe pulmonary impairment which would prevent him from performing his usual or last coal mine employment. He also found that Claimant's pulmonary impairment is caused, to a major extent, by his pneumoconiosis, exertional angina and hypertension. (DX 35).

Dr. Ranavaya submitted an examination report, based upon his third examination of the claimant, on October 17, 2002. He notes 25 years of coal mine employment. Dr. Ranavaya noted that Claimant never smoked. (DX 97). Dr. Ranavaya repeated Claimant's medical history from his first examination and added diabetes mellitus to Claimant's medical history. Dr. Ranavaya described the claimant's symptoms as daily wheezing, dyspnea, occasional cough, occasional chest pain after coughing, orthopnea, and paroxysmal nocturnal dyspnea. He stated that Claimant complains of shortness of breath upon minimal to mild exertion. (DX 97).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed pneumoconiosis, coronary artery disease and hypertension. Dr. Ranavaya noted that his diagnosis of pneumoconiosis is based on 25 years of coal mine dust exposure and radiological evidence of pneumoconiosis. (DX 97).

Dr. Ranavaya found a "moderate impairment as reflected by moderate hypoxemia at rest which meets federal criteria for total disability as contained in 20 C.F.R. 718." He stated that claimant's pneumoconiosis, coronary artery disease and hypertension contributed to a major extent to his total disability. (DX 97). A resting arterial blood gas study is included in Dr. Ranavaya's report. No pulmonary function study results are included. Dr. Ranavaya noted "Mr. Fleming declined from undergoing breathing test and stated, 'I just don't think I can take it.'" (DX 97).

Dr. James Walker, whose qualifications are not in the record, examined the Claimant at the Charleston Area Medical Center – Occupational Lung Center for the Department of Labor, on April 9, 1999. Dr. Walker noted 26 years of coal mine employment and that Claimant never smoked cigarettes. Dr. Walker listed Claimant's medications as Atenolol, aspirin, Theophylline-XR, Phenyltoloxaminew/aceta, Azmacort, Atrovent, Vanceril and Albuterol. (DX 53, 57).

Dr. Walker stated that Mr. Fleming complains of chronic cough productive of white/yellow sputum, wheezing, shortness of breath, and left anterior chest pain following severe coughing. He noted that Claimant uses three pillows for sleeping. (DX 57). Dr. Walker concluded that Claimant was not in any respiratory distress at rest. He found rales and wheezing throughout both lung fields. (DX 57).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Walker diagnosed bronchitis with bronchospasm. He stated that Claimant's bronchitis with bronchospasm is caused by coal dust exposure. Dr. Walker concluded that Claimant does not have coal workers' pneumoconiosis. Dr. Hayes interpreted the X-ray taken during the April 9,

1999 examination. He noted less than optimal degree of inspiration despite repeated attempts. When listing the results of diagnostic testing, Dr. Walker noted that the pulmonary function study shows minimal restrictive ventilatory defect. He does not discuss the arterial blood gas. Dr. Walker does not note what caused the ventilatory defect. (DX 53).

The record also includes a report by Dr. William Harris, dated January 5, 1996. Dr. Harris filled out a Physician's Report of Occupational Pneumoconiosis for the West Virginia Workers' Compensation Fund. (DX 30). Dr. Harris concluded that Mr. Fleming has occupational pneumoconiosis. He noted that the Claimant had been suffering from pneumoconiosis for two years. He stated that Claimant's capacity to work has been impaired by pneumoconiosis. Dr. Harris did not, however, state the extent of Claimant's impairment. Dr. Harris noted that Claimant has a history of pleurisy and asthma. (DX 30).

III. Hospital Records & Physician Office Notes

The record includes treatment records from Associated Radiologists, Inc. and the V.A. Medical Center in Huntington, West Virginia. (DX 30).

Associated Radiologists, Inc.:

Dr. Sexton noted that a March 10, 1981 X-ray is radiographically normal.

On March 8, 1985, Dr. Cordell performed a chest examination of Claimant. Dr. Cordell concluded that the pulmonary vascularity is normal and there is no acute pulmonary infiltrate. He also noted linear fibrotic scarring in the left lung base.

Dr. Sexton examined Claimant's chest and colon on June 16, 1986. Dr. Sexton stated that "[T]he heart, lungs and thoracic cage appear radiographically normal."

On September 29, 1992, Dr. Reifsteck reviewed a chest X-ray of Mr. Fleming. Dr. Reifsteck stated "[T]here are some increased lung markings in the right lung base which would be consistent with atelectasis. There is also some linear atelectasis in the left lower lung. No other signs of consolidation are noted within the lung."

On October 5, 1995, Dr. Benson compared a chest X-ray of Mr. Fleming to a September 29, 1992 chest X-ray of Mr. Fleming. Dr. Benson noted hyperventilatory changes. He noted chronic changes with perhaps some compressive atelectatic changes. Dr. Benson noted that he cannot exclude some superimposed patchy atelecatic changes within the left lung base.[12]

V.A. Medical Center:

On July 17, 1995, Dr. Gore interpreted a chest X-ray of Claimant. Dr. Gore noted a small area of patchy added density seen at the left lung base. He concluded that there was no evidence of pulmonary edema or pleural effusion. (DX 30).[13]

[12] This has also been included as DX 23.

[13] This exhibit also contains various unreadable Clinical Progress Notes dated from 1995 through 1996. A November 8, 1995 progress note states "COPD vs occupational lung disease." A December 13, 1995 progress note

IV. Claimant's Testimony

Raymond Fleming testified at the hearing on May 20, 2004. (TR 11). Mr. Fleming explained that he has difficulty breathing and takes breathing medications and inhalers to help alleviate his symptoms. Mr. Fleming is treated for his breathing difficulties at the V.A. Medical Center. (TR 12). Claimant testified that he has difficulty sleeping at night and needs to get up after an hour. (TR 13). Mr. Fleming stated that his breathing problems do not make it possible for him to go back to work. (TR 14).

Mr. Fleming testified at an April 5, 2000 hearing presided over by Administrative Law Judge Lesnick. (DX 77). Mr. Fleming testified that he has difficulty sleeping at night due to his breathing problems. Claimant stated that he has shortness of breath on a daily basis. Claimant takes breathing pills, inhalers and cough syrup for his breathing difficulties. Claimant testified that he has never smoked cigarettes. (DX 77). On November 22, 2000, Judge Lesnick remanded the claim to the District Director. (DX 79).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986).

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[14]

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states COPD. It is unclear, however, whether this is a diagnosis or something the doctor wanted to investigate further.

[14] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[15] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound

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(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[15] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[16] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

The Claimant's most recent X-ray is dated November 27, 2002. Six dually qualified physicians interpreted this X-ray as positive for coal workers' pneumoconiosis. Three dually qualified physicians and one B-reader interpreted the X-ray as negative for coal workers'

[16] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

pneumoconiosis. Based on the physician qualifications and the majority readings as positive, I find the November 27, 2002 X-ray positive for coal workers' pneumoconiosis.

An October 17, 2002 X-ray was interpreted as positive by five dually qualified physicians and one B-reader. Two dually qualified physicians interpreted the X-ray as negative for pneumoconiosis. Dr. Gaziano provided a quality-only reading. Based on the physician qualifications and the majority readings as positive, I find the October 17, 2002 X-ray positive for coal workers' pneumoconiosis.

Seven dually qualified physicians interpreted the April 9, 1999 X-ray as positive for pneumoconiosis. Five dually qualified physicians interpreted the X-ray as negative for pneumoconiosis. I find that the physicians interpreting the April 9, 1999 X-ray are equally qualified. Thus, based on the majority readings, I find the April 9, 1999 X-ray positive for coal workers' pneumoconiosis.

Six dually qualified physicians and one B-reader interpreted the December 12, 1996 X-ray as positive for pneumoconiosis. Four dually qualified physicians and one B-reader interpreted the X-ray as negative. Based on the majority readings and physician qualifications, I find the December 12, 1996 X-ray positive for coal workers' pneumoconiosis.

Six dually qualified physicians interpreted the July 8, 1994 X-ray as positive for pneumoconiosis. Four dually qualified physicians and One B-reader interpreted the X-ray as negative. Based on the majority readings and physician qualifications, I find the July 8, 1994 X-ray positive for coal workers' pneumoconiosis.

In summary, I find all five chest X-rays of the Claimant positive for coal workers' pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[17] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

[17] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Zaldivar and Ranavaya above Drs. Walker and Harris.

Dr. Zaldivar opined that Claimant does not have coal workers' pneumoconiosis. He determined that Claimant's shortness of breath is due to general deconditioning and advanced age, not a pulmonary disease/condition. Dr. Zaldivar listed the medical evidence of the claimant that he reviewed in addition to his own examination of the Claimant. The list contains ten X-ray readings interpreted as positive for pneumoconiosis. Dr. Zaldivar provided no explanation of why these X-ray readings are positive when he concluded that the Claimant has no pulmonary condition. Dr. Zaldivar's report states "[H]is chest X-ray showed that he has never taken a deep breath during the performance of the radiograph." It is not clear if Dr. Zaldivar concluded that all of the chest X-rays are not of value for failure to take a deep breath, or if that conclusion only applies to the X-ray taken during Dr. Zaldivar's examination. Furthermore, Dr. Zaldivar does not explain why failure to take a deep breath would result in highly qualified physicians interpreting an X-ray as positive for pneumoconiosis. I find that Dr. Zaldivar's opinion does not correspond with the objective evidence. As such, I accord little weight to Dr. Zaldivar's opinion regarding coal workers' pneumoconiosis.

Dr. Ranavaya examined the Claimant on three occasions. In 1994, Dr. Ranavaya diagnosed Mr. Fleming with hypertension. When Dr. Ranavaya examined Mr. Fleming in 1996 and 2002, he opined that the Claimant has coal workers' pneumoconiosis. Dr. Ranavaya also diagnosed hypertension during the 1996 and 2002 examinations. I find Dr. Ranavaya's opinion reasoned and supported by the objective evidence of record. I accord more weight to Dr. Ranavaya's opinion than Dr. Zaldivar's opinion due to the fact that Dr. Ranavaya had the opportunity to evaluate the progression of Claimant's pulmonary condition with three examinations spanning from 1994 through 2002.

Dr. Walker diagnosed the Claimant with bronchitis with bronchospasm caused by coal dust exposure. Dr. Walker did not diagnose coal workers' pneumoconiosis. Although Dr. Walker did not diagnose clinical pneumoconiosis, I find that his diagnosis of bronchitis with bronchospasm caused by coal dust exposure meets the definition of legal pneumoconiosis. As noted above, Dr. Walker's qualifications are not in the record and, as such, I rank Drs. Ranavaya and Zaldivar above Dr. Walker. I do find, however, that Dr. Walker provided a reasoned and documented medical opinion. Dr. Walker's letterhead is from the Charleston Area Medical Center – Occupational Lung Center. I, therefore, infer that he is a doctor experienced in dealing with occupational lung disease.

Dr. Harris' opinion is documented on a West Virginia Workers' Compensation Fund form. Dr. Harris merely checks "yes" or "no" to questions on the form. In response to the question: "In your opinion has claimant contracted occupational pneumoconiosis?" – Dr. Harris checked the box marked "yes." I find that Dr. Harris' opinion is supported by the Claimant's objective evidence. However, I accord little weight to Dr. Harris' opinion due to the fact that he merely checked "yes" or "no" answers as opposed to providing a detailed explanation of his opinion.

In summary, I find the opinion of Dr. Ranavaya more persuasive than the opinions of Drs. Zaldivar, Walker and Harris. Dr. Ranavaya provided a reasoned opinion based on three complete examinations of the Claimant over an eight year period. I accord little weight to Dr. Zaldivar's opinion that Claimant has no pulmonary disease due to the fact that there is overwhelming objective evidence supporting a contrary opinion. I accord more weight to Dr. Ranavaya's opinion than Drs. Walker and Harris due to the fact that the qualifications of Drs. Walker and Harris are not in the record.

Although I reviewed the treatment records from Associated Radiologists, Inc. and the V. A. Medical Center in Huntington, West Virginia (DX 30), I accord more weight to the X-ray evidence included in Appendix A and the physician opinions. The dates of the evidence in Director's Exhibit 30 range from 1981 through 1995. Due to the fact that pneumoconiosis is a latent and progressive disease, I find that the more recent evidence of record is more beneficial in determining whether Claimant has coal workers' pneumoconiosis. After Weighing the X-rays, physician opinions, and treatment records, I find the claimant has met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b).

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Nor does the record contain contrary evidence that establishes the claimant's pneumoconiosis arose out of alternative causes.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[18] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must

[18] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718.

Five pre-bronchodilator and two post-bronchodilator pulmonary function studies are included in the record. The only qualifying test is a pre-bronchodilator test performed by Dr. Ranavaya in 1996. Dr. Ranavaya determined that the spirometry is inconclusive due to submaximal effort. Additionally, Dr. Gaziano reviewed the December 12, 1996 pulmonary function study. Dr. Gaziano determined that the vents are not acceptable due to poor effort. As such, I find the December 12, 1996 pulmonary function study is not a valid study. Therefore, as there are no valid qualifying pulmonary function studies, the claimant did not prove total disability by pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii).

The record contains the results of six arterial blood gas studies. No exercise studies were performed. Four of the studies produced qualifying results. Based on a majority of the studies producing qualifying results, I find the claimant established total disability by arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the

party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As noted above, the record contains the opinions of Drs. Ranavaya, Zaldivar, Walker and Harris. Dr. Zaldivar found no evidence of any pulmonary impairment. He concluded that Mr. Fleming is fully capable of performing his usual coal mine work. Dr. Ranavaya examined Mr. Fleming three times. During the first examination, Dr. Ranavaya did not note any pulmonary impairment, nor did he diagnose coal workers' pneumoconiosis. At the second and third examinations, Dr. Ranavaya concluded that Mr. Fleming is totally disabled. Dr. Walker noted only a minimal respiratory defect. Dr. Harris concluded that Claimant's ability to work has been impaired by pneumoconiosis. He does not state the extent of impairment.

As discussed previously, based on physician qualifications, I rank Drs. Ranavaya and Zaldivar above Drs. Walker and Harris. I accord the most weight to Dr. Ranavaya's opinion. Dr. Ranavaya examined the Claimant on three occasions and his conclusions are supported by objective evidence. I give less weight to Dr. Zaldivar's finding of no impairment based on the numerous objective tests supporting some level of impairment. Furthermore, Dr. Zaldivar stated that the pulmonary function study performed during his examination of the claimant was "worthless" due to poor effort. Dr. Zaldivar listed that he reviewed various other breathing tests of the Claimant; however, it is unclear if Dr. Zaldivar relied solely on the "worthless" breathing test during his examination to determine Claimant's level of pulmonary impairment or if he analyzed the other tests of record in making his determination that Claimant has no impairment. An arterial blood gas study performed during Dr. Walker's examination produced qualifying results. Dr. Walker notes the breathing defect found in the pulmonary function study, but does not comment on or discuss the qualifying arterial blood gas study. Based on the fact that he did not discuss the qualifying arterial blood gas study when analyzing claimant's level of impairment, I accord Dr. Walker's opinion regarding total disability little weight. As previously stated, Dr. Harris provided merely "yes" or "no" answers with no detailed explanation. Therefore, I find that his opinion cannot support a finding of total disability, nor is it persuasive support for finding that the claimant is not totally disabled. In conclusion, I find that Dr. Ranavaya's opinion supports a finding of total disability.

I find that the miner's last coal mining positions required heavy manual labor. Claimant testified that he was required to lift 50 to 70 pounds.

A medical opinion based on an invalid study may be rejected. *See Director v. Siwiec,* 894 F.2d 635, 639 (3d Cir. 1990) (cited with approval in *Lane v. Union Carbide & Director, OWCP*, 21 B.L.R. 2-34, 2-47, 105 F.3d 166 (4th Cir. 1997).

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments.'" Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for

benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

In determining whether Mr. Fleming is totally disabled, I accord the most weight to the arterial blood gas studies and Dr. Ranavaya's opinion. Due to the numerous findings of "poor effort" during pulmonary function studies, I conclude that the non-qualifying pulmonary function studies do not contradict a finding of total disability based on the arterial blood gas studies and Dr. Ranavaya's opinion. As such, I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability[19]

The revised regulations, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).[20]

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[21] *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

"A claimant must be totally disabled due to pneumoconiosis and any other respirator or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd*

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[19] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. __, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

[20] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[21] *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L..R 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or 'substantial' cause." *Id.*

49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.* (So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability). The fact that a physician does not explain how he could distinguish between disability due to coal mining and cigarette smoking or refer to evidence which supports his total disability opinion, may make this opinion "unreasoned." *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59 (1984).

It is proper for judge to accord less weight to physicians' opinions which found that pneumoconiosis did not contribute to the miner's disability on the grounds that the physicians did not diagnose pneumoconiosis. *Osborne v. Westmoreland Coal Co.*, ___ B.L.R. ___, BRB No. 96-1523 BLA (April 30, 1998).

Where an Administrative Law Judge determines that a miner suffers from pneumoconiosis, a medical opinion finding the miner does not suffer from the disease "can carry little weight" in assessing the etiology of the miner's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 116 (4th Cir. 1995). *Grigg v. Director, OWCP*, 28 F.3d 416, 419 (4th Cir. 1994). If a physician finds no respiratory or pulmonary impairment based on an erroneous diagnosis that the miner does not suffer from pneumoconiosis, her opinion is "not worth of much, if any, weight." *Citing Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Picklands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).[22]

Dr. Ranavaya concluded that Claimant's coal workers' pneumoconiosis contributed to a major extent to his total disability. Dr. Harris concluded that Claimant's pneumoconiosis impaired his capacity to work. Dr. Harris does not state the extent of Claimant's impairment. Mr. Fleming has no smoking history. Dr. Zaldivar did not diagnose Claimant as totally disabled. Furthermore, Dr. Zaldivar's opinion regarding causation of impairment is entitled to little weight due to the fact that he did not diagnose coal workers' pneumoconiosis and did not provide specific and persuasive reasons for crediting his opinion. There is no evidence in the record that Claimant's pulmonary impairment is caused by another factor. As such, I find that the evidence establishes that pneumoconiosis is a contributing factor of Claimant's total disability.

F. Date of Entitlement[23]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis.[24] 20 C.F.R. § 725.503. Because no specific onset date of disability is evident

[22] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claim…in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

[23] 20 C.F.R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[24] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1310 (1984).

from the record, benefits will begin on the first day of the month in which he filed this claim. 20 C.F.R. § 725.503(b).[25] The Claimant filed his claim on June 2, 1994.

ATTORNEY FEES

An application by the claimant's attorney for approval of a fee has not been received; therefore no award of attorney's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365-725.366. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the claimant has pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis arose out of his coal mine employment. The claimant is totally disabled. His total disability is due to pneumoconiosis. He is therefore entitled to benefits.

ORDER[26]

It is ordered that the claim of RAYMOND FLEMING for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the BLACK LUNG DISABILITY TRUST FUND shall pay[27] to the claimant all benefits to which he is entitled under the Act commencing June 1, 1994.

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits,

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[25] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). ALJ merely concluded, in general terms, that the evidence did not establish an exact date of onset of total disability. This was error. In determining the onset date, the Administrative Law Judge must consider all relevant evidence of record and assess the credibility of that evidence. *Lykins, supra* at 1-183.

[26] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[27] 20 C.F.R. § 725.502(a)(1)(65 Fed. Reg. 80085, Dec. 20, 2000) provides "Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated."

and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[28]

[28] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

APPENDIX A

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
CX 4	11/27/2002 4/28/2004	Dr. Alexander	B, BCR	3 under exposure	1/1	Small rounded opacities are present bilaterally, consistent with pneumoconiosis, category p/q, 1/1. No pleural thickening.
DX 114	11/27/2002 6/6/2003	Dr. Aycoth	B, BCR	1	1/2	Pneumoconiosis category ½, p/q.
DX 112	11/27/2002 4/11/2003	Dr. Miller	B, BCR	2	1/1	Findings consistent with pneumoconiosis, category t/p, profusion 1/1. Grade A left lateral pleural thickening, extent 2. Heart size difficult to evaluate. Minimal linear atelectasis or scarring left base.
DX 112	11/27/2002 4/8/2003	Dr. Cappiello	B, BCR	1	1/1	Pneumoconiosis category p/q, 1/1. Left chest wall pleural thickening, Grade A, Extent 1.
DX 112	11/27/2002 4/4/2003	Dr. Ahmed	B, BCR	2	1/1	Simple pneumoconiosis category p/q, 1/1.
DX 112	11/27/2002 4/2/2003	Dr. Pathak	B, BCR	2	1/1	Pulmonary pneumoconiosis category p/q, 1/1. No acute pulmonary pathology.
DX 107	11/27/2002 2/19/2003	Dr. Scott	B, BCR	3 under exposure		Hypoinflation lungs. Minimal discoid atelectasis or linear fibrosis left lower lung.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 107	11/27/2002 2/19/2003	Dr. Scatarige	B, BCR	3 under exposure		No definite interstitial lung disease. But advise repeat Pa, deep inspiration and heavy technique. Tortuosity thoracic aorta.
DX 107	11/27/2002 2/19/2003	Dr. Wheeler	B, BCR	3 under exposure		Hypoinflation lungs probably due to obesity which may be mainly intraabdominal or ascites. Check clinically. Small discoid atelectasis or scar left lower lateral lung.
DX 103	11/27/2002 1/2/2003	Dr. Zaldivar	B, BCP(I)	3 poor effort		Poor inspiratory effort resulting in crowding of blood vessels.
CX 16	10/17/2002 7/21/2004	Dr. Cappiello	B, BCR	1	1/1	Pneumoconiosis category p/s, 1/1. Right chest wall pleural thickening, Grade A, extent 1. Left Chest wall pleural thickening, Grade A, extent 2.
CX 19	10/17/2002 7/19/2004	Dr. Aycoth	B, BCR	1	1/0	Pneumoconiosis category 1/0, p/p.
CX 17	10/17/2002 7/15/2004	Dr. Ahmed	B, BCR	1	1/1	Simple pneumoconiosis category p/q, 1/1. Left peripheral pleural thickening, width A, Extent 2. Right peripheral pleural thickening, width A, Extent 1.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
CX 18	10/17/2002 7/8/2004	Dr. Pathak	B, BCR	1	1/1	Pulmonary pneumoconiosis category p/q, 1/1. Bilateral chest wall pleural thickening, width A, extent 3 on the left and width A, extent 1 on the right.
CX 15	10/17/2002 7/7/2004	Dr. Miller	B, BCR	1	1/0	Findings consistent with pneumoconiosis, category q/t, profusion 1/0. Grade A bilateral pleural thickening, extent 2.
DX 107	10/17/2002 3/8/2003	Dr. Wheeler	B, BCR	1		Obesity which is mainly intraabdominal and mediastinal contributes to hypoinflation lungs with minimal degenerative arthritis in right lung base near diaphragm dome and few tiny bands of discoid atelectasis or scar in left lower lateral lung and one in right lateral CPA seen on one pa view. Minimal tortuosity descending thoracic aorta and no other abnormality.
DX 107	10/17/2002 3/7/2003	Dr. Scott	B, BCR	1		Discoid atelectasis or few linear scars lower lungs. Obesity.
DX 97	10/17/2002 1/9/2003	Dr. Gaziano	B, BCI	1		Quality-only reading.
DX 97	10/17/2002 10/17/2002	Dr. Ranavaya	B	1	1/0	p/s. all zones.
CX 22	4/9/1999 9/23/2004	Dr. Brandon	B, BCR	2	2/1	

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
CX 10	4/9/1999 5/21/2004	Dr. Pathak	B, BCR	1	1/1	Pulmonary pneumoconiosis category p/q, 1/1.
CX 3	4/9/1999 4/29/2004	Dr. Ahmed	B, BCR	1	1/0	Simple pneumoconiosis category p/q, 1/0. Left peripheral pleural thickening, width A, extent 3. Right peripheral pleural thickening, width A, extent 2.
DX 121	4/9/1999 11/5/2002	Dr. Scatarige	B, BCR	1		Marked hypoinflation lungs. Discoid atelectasis in lingual and LLL. Obesity. Calcified mode R hilum.
DX 120	4/9/1999 11/5/2002	Dr. Scott	B, BCR	1		Discoid atelectasis left lower lung. Obesity. Hypoinflation lungs.
DX 102	4/9/1999 11/5/2002	Dr. Wheeler	B, BCR	2		Moderate hypoinflation lungs probably due to obesity which may be mainly intraabdominal causing minimal discoid atelectasis in left lower lateral lung. Minimal tortuosity descending thoracic aorta.
DX 70, 67	4/9/1999 12/29/1999	Dr. Cappiello	B, BCR	1	1/0	Pneumoconiosis category p/q, profusion 1/0. Left chest wall pleural thickening, Grade A, extent 2.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 70, 67	4/9/1999 12/21/1999	Dr. Miller	B, BCR	1	1/0	Findings consistent with simple pneumoconiosis, category p/q, profusion 1/0. Grade A bilateral pleural thickening, extent 3. Small atelectasis or infiltrate at the left base.
DX 70, 67	4/9/1999 12/15/1999	Dr. Aycoth	B, BCR	1	1/0	Pneumoconiosis category 1/0, p/p.
DX 70, 66	4/9/1999 10/30/1999	Dr. Alexander	B, BCR	1	1/1	Small round and irregular opacities are present bilaterally, consistent with pneumoconiosis, category p/t, 1/1. Unilateral chest wall pleural thickening.
DX 56	4/9/1999 5/7/1999	Dr. Navani	B, BCR	3 poor inspira-tion		No abnormalities consistent with pneumoconiosis. Coarse linear densities in L. L. zone are likely to be due to fibrotic strands.
DX 57, 55	4/9/1999 4/15/1999	Dr. Hayes	B, BCR	2 poor inspira-tion	0/0	There are linear areas of subsegmental fibrosis in the left lung base. Insufficient pleural or parenchymal changes to establish a diagnosis of occupational pneumoconiosis.
CX 8	12/12/1996 6/4/2004	Dr. Miller	B, BCR	2	1/0	Findings consistent with pneumoconiosis, category t/p, profusion 1/0. Difficult to evaluate heart size due to poor inspiratory effort.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
CX 9	12/12/1996 5/21/2004	Dr. Pathak	B, BCR	2	1/1	Pulmonary pneumoconiosis category p/q, 1/1. Left lateral chest wall pleural thickening, width A, extent 3.
CX 1	12/12/1996 5/3/2004	Dr. Cappiello	B, BCR	2	1/0	Pneumoconiosis category p/p, 1/0. Left chest wall pleural thickening, Grade A, extent 2.
CX 2	12/12/1996 4/29/2004	Dr. Ahmed	B, BCR	1	1/1	Simple pneumoconiosis category p/s, 1/1. Indistinct diaphragm.
DX 121	12/12/1996 11/5/2002	Dr. Scatarige	B, BCR	3 under exposure. Hypo-inflation		Marked hypoinflation lungs. 1 cm nodule in RML or lingual, seen only in lateral view – advise CT. discoid atelectasis. No evidence of CWP/silicosis.
DX 120	12/12/1996 11/5/2002	Dr. Scott	B, BCR	2		Minimal discoid atelectasis left lower long. Obesity. Hypoinflation lungs.
DX 102	12/12/1996 11/5/2002	Dr. Wheeler	B, BCR	2		Moderate hypoinflation lungs probably due to obesity which may be mainly intraabdominal with tiny linear discoid atelectasis or scar left lower lateral lung. No other abnormality.
DX 44	12/12/1996 7/30/1998	Dr. Aycoth	B, BCR	1	1/0	Simple pneumoconiosis category 1/0, p/q. Grade A bilateral pleural thickening.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 43	12/12/1996 6/20/1998	Dr. Alexander	B, BCR	2 poor inspira-tion and slight under-exposure	1/2	Pneumoconiosis, category p/p, ½, id, pi. Unilateral chest wall pleural thickening.
DX 37	12/12/1996 1/27/1997	Dr. Cole	B, BCR	2 under exposed	0/1	Obesity.
DX 38	12/12/1996 1/18/1997	Dr. Gaziano	B, BCP(I)	2 poor inspira-tion		Film is completely negative.
DX 39	12/12/1996 12/12/1996	Dr. Ranavaya	B	1	1/0	
CX 21	7/8/1994 9/23/2004	Dr. Brandon	B, BCR	2	2/1	
CX 13	7/8/1994 7/15/2004	Dr. Ahmed	B, BCR	1	1/1	Simple pneumoconiosis. p/q.
CX 14	7/8/1994 7/8/2004	Dr. Pathak	B, BCR	1	1/1	Simple pneumoconiosis category p/p, 1/1.
DX 121	7/8/1994 11/5/2002	Dr. Scatarige	B, BCR	2		Hypoinflation lungs. Discoid atelectasis, lingual and RLL. No evidence of CWP, silicosis. Healed fractures ant R 2^{nd} – 5^{th} ribs.
DX 120	7/8/1994 11/5/2002	Dr. Scott	B, BCR	2		Minimal discoid atelectasis or linear scar left lower lung. Hypoinflation lungs. Obesity.
DX 102	7/8/1994 11/5/2002	Dr. Wheeler	B, BCR	2		Normal except hypoinflation lungs possibly due to obesity which may be mainly intraabdominal and minimal discoid atelectasis left lower lateral lung.
DX 44	7/8/1994 7/30/1998	Dr. Aycoth	B, BCR	1	1/0	Simple pneumoconiosis category 1/0, p/q.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 44	7/8/1994 7/31/1998	Dr. Cappiello	B, BCR	1	1/1	Simple pneumoconiosis category p/q with profusion of 1/1. Left chest wall pleural thickening Grade A, extent 1.
DX 43	7/8/1994 6/20/1998	Dr. Alexander	B, BCR	1	1/1	Pneumoconiosis, category p/p, 1/1, pi. Unilateral chest well pleural thickening.
DX 11	7/8/1994 9/7/1994	Dr. Harron	B, BCR	1		Film is completely negative.
DX 10	7/8/1994 7/8/1994	Dr. Ranavaya	B	1	0/1	

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.